Letters

SSRIs IN PEDIATRIC PATIENTS

"SSRIs in children and adolescents: Where do we stand?" (CURRENT PSYCHIATRY, March 2004, p. 83-89) is excellent and timely.

As a child psychiatrist working in inpatient and outpatient settings, I have often seen activation and dysphoria in depressed children taking selective serotonin reuptake inhibitors (SSRIs). Drs. A. Bela Sood, Elizabeth Weller, and Ronald Weller reflect my view that "bipolar illness may be a possible explanation." Without a high index of suspicion for bipolarity and a thorough family history, physicians are likely to be surprised when suicidality emerges after starting an antidepressant.

SSRIs clearly have contributed to the well-being of children with mood and anxiety disorders and are safe and effective in clinical practice. Unfortunately, the article does not address the dangers of using SSRIs in youths with bipolar disorder.

Stephen J. Wieder, MD
Newburyport, MA

The authors respond

Dr. Wieder raises a pertinent clinical question regarding use of SSRIs in children at risk for bipolar disorder. SSRIs could cause hypomania or mania in depressed children with a clear history of bipolar disorder. When the clinical picture is not as clear, however, keep the following data in mind.

Follow-up studies have shown that 20% to 40% of adolescents with major depression develop bipolar type I disorder within 5 years after onset of depression.[1] The clinician must strongly consider using prophylactic mood stabilizers along with SSRIs in depressed adolescents who present with psychomotor retardation, psychosis, family history of bipolar illness, and previous hypomanic disinhibition secondary to SSRI use, as these predict future bipolar disorder.[2,3] Baseline irritability and aggression should also contraindicate SSRI monotherapy in unipolar depression, as exacerbation of rage and impulsivity with SSRIs seems to be high in this population.

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SKIN PICKING: ONE TEENAGER'S STRUGGLE

I am most grateful for "Captive of the mirror" (CURRENT PSYCHIATRY, December 2003, p 45-52) by Drs. Jon Grant and Katharine Phillips.

I am a 19-year-old female college student who has been diagnosed with depression, anxiety, and trichotillomania. I have bitten my nails all my life, have been taking SSRIs since age 12, and have had numerous problems related to skin-picking. Since adolescence I have obsessively picked and squeezed at acne and miniscule bumps on my face, causing redness, bruising and—in some cases—bleeding. I would then hide from the world, sometimes for days, until the wounds healed.

Letters

Until now, I didn't know skin picking was a recognized disorder, let alone common. Your article is a detailed, clear, evidence-based summary of the problem and possible treatments, most of which I never knew existed. After having tried many things with limited success, I am taking the article to a psychiatrist so that I can discuss options. For the first time in months, I am filled with hope.

(Editor's Note: The author's name is being withheld to protect her privacy.)

WRITING PRESCRIPTIONS ON PDAs

Dr. John Luo's article, "Handhelds: A cure for illegible prescriptions" (CURRENT PSYCHIATRY, April 2003 online edition), missed some important issues.

First, once a practice computerizes or installs a network—especially a wireless network—the physician needs to guard against HIPAA violations. Each violation could result in a fine ranging from $100,000 to $1 million. The switch to a Palm-, local area network-, or Internet-based program requires security procedures and operation controls.

Second, medical file management programs offer prescription writing, but as an accessory. Prescription writing should be the prominent component of any software title.

Third, during a power failure you need back-up power and database recovery software to bring your system back up if it crashes. This not only protects your database, but also ensures that your patient files and formulary are available during an emergency, when risk is greatest.

Finally, let's say 10 patient files fall to the floor. The contents are spilled, and you hastily pick up and re-collate the files. Incorrectly collating the files will not lead to a malpractice suit.

Now let's say your system crashes, wiping out those same 10 Internet database files, and you

continued on page 75

Meet the editor

CURRENT PSYCHIATRY welcomes Anthony J. Rothschild, MD, as an Associate Editor. He joins our board of distinguished psychiatrists who recommend the journal's topics and authors.

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Educational and professional background

Anthony Rothschild received his bachelor's degree from Princeton University and medical degree from the University of Pennsylvania School of Medicine. His residency and fellowship in psychiatry at Harvard Medical School and McLean Hospital focused on psychopharmacology and affective disease. He was associate professor of psychiatry at Harvard Medical School before being appointed professor of psychiatry at the University of Massachusetts Medical School.

Clinical areas of interest

Mood disorders and psychopharmacology, particularly psychotic depression and sexual side effects of antidepressants.

Perspectives on psychiatry

Mood disorders are the most common psychiatric disorder seen in clinical practice. Although often very treatable, they can result in significant morbidity and mortality.

In recent years, physicians in other specialties have been treating first-episode and uncomplicated mood disorders, leaving the more difficult-to-treat patients (treatment-resistant, bipolar, psychotic, suicidal) for the practicing psychiatrist.

As a member of CURRENT PSYCHIATRY's board of Associate Editors, I hope to contribute to the practicing psychiatrist's knowledge and understanding of mood disorders.